Treatment Episode Data Set

Treatment episode data must be submitted for all individuals who receive substance use disorder and/or problem gambling treatment. The Client file must already exist in the IBHRS before Treatment Episode data can be submitted.

Treatment Episode data should be updated after any record in the Provider Treatment Episode (e.g. Care Status, Diagnosis, and Performance Outcome Measure) needs to be added, changed, or removed.

Profile

First Contact Date*			
Concerned Person*	☐ Yes ☐ No	Referral Source* *See vocabulary key for all Referral Source Types*	
Evaluator Allowed to Contact Client*	☐ Yes ☐ No	Scheduled Admission Date*	
Intravenous Substance Use in Past 30 Days*	☐ Yes ☐ No ☐ NA	Pregnant at First Contact Date*	☐ Yes ☐ No ☐ NA
Open Date*		Closed Date	

Provider

IBHRS will default to your Provider Agency. If it does not, you can search for your Provider Agency in the Data Entry Screens.

Provider Client

Within the IBHRS Data Entry Screens you will be required to search for the Client associated with each Treatment Episode.

Special Initiative

During a Treatment Episode, no two Special Initiative records with the same Type Code may have overlapping dates. The Start Date for a Special Initiative must be greater than or equal to the Open Date of the associated Treatment Episode. If provided, the End Date for a Special Initiative must be less than or equal to the Closed Date, if there is a Closed Date.

Special Initiative Type *Only applicable if associated with a corresponding Provider Contract Type*	☐ Women and Children ☐ State Opioid Response (SOR)	Start Date
End Date	Children in Care with Client Count *Required if Special Initiative Type is Women and Children*	

Care Status

There can only be one Admission Care Status for each program area within a Treatment Episode. Subsequent Care Statuses should have the Transfer or Discharge type.

Profile

Status*	*If the Care Status has a Status Code value of Pre-admission, only the Status Date and Status Code should be supplied for this Care Status. No other fields are required.* ☐ Pre-Admission ☐ Admission ☐ Transfer ☐ Discharge
Status Date*	Program Area ☐ Substance Use Disorder Treatment ☐ Gambling treatment
In Care for Mental Health Disorder *Required if Care Status Code is Admission*	☐ Yes ☐ No ☐ Refused
Prior Substance Use Episode Known *Required if Care Status Type is Admission*	☐ Yes ☐ No ☐ Refused
Prior Substance Use Episode Count *Required if Known is Yes*	
Prior Gambling Episode Known *Required if Care Status Type is Admission*	☐ Yes ☐ No ☐ Refused
Prior Gambling Episode Count *Required if Known is Yes*	
Prior Mental Health Episode Known *Required if Care Status Type is Admission*	☐ Yes ☐ No ☐ Refused
Prior Mental Health Episode Count *Required if Known is Yes*	
Concerned Person Involved *Only report when Care Status Code is Discharge*	☐ Yes ☐ No
Discharge Reason *Only report when Care Status Code is Transfer or Discharge*	☐ Treatment completed ☐ Terminated by facility ☐ Incarcerated or released by or to courts ☐ Transferred to another treatment program or facility but client is no show ☐ Discharged from the State Hospital to an acute medical facility for medical purposes ☐ Dropped out of treatment ☐ Death ☐ Transferred to another treatment program or facility ☐ Transferred to another treatment program or facility that is not in the SSA or SMHA reporting system ☐ Other

Provider Site

Within the IBHRS Data Entry Screens you will be required to search for the Provider Site associated with each Care Status.

ASAM

ASAM Level of Care *See vocabulary key for all ASAM Levels of Care.* *Required for all Care Status Types except Pre-Admission.* *Discharge Care Status ASAM Level of Care should be the same as the Predecessor Care Status ASAM Level of Care.*	Recommended Level of Care *See vocabulary key for all Recommended Levels of Care* *Required for Care Status Type of Admission*

Clinical Override Reason *Required if Recommended Level of Care is different from ASAM Level of Care*	☐ Lack of insurance benefits ☐ Clinical judgment ☐ Level of care not available ☐ N/A	☐ Managed care refusal ☐ Patient opinion ☐ Legal issues ☐ Other

Predecessor Care Status

If a Care Status has a Status of Transfer or Discharge, then the Predecessor Source Record Identifier must exist and reference a Care Status within the same Provider Treatment Episode and Program Area. The referenced Care Status must have a Status of Transfer or Admission.

Within the IBHRS Data Entry Screens you can search for the Predecessor Care Status.

Performance Outcome Measure

Each Care Status must have at least one associated Performance Outcome Measure record.

Profile

Pregnant Last 12 Months*	☐ Yes	☐ No	☐ Refused

Performance Outcome Measure Date*	Days Substance Used in Past 30 Days* *Required is Care Status type is Substance Use*
Days Gambled in Past 30 Days* *Required is Care Status type is Gambling*	Pregnant* ☐ Yes ☐ No ☐ Not Applicable

Pre-Screening

Required for Pre-Admission Care Status unless it is for a Concerned Person.
Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Gambling in Past 12 Months Number*		Binge Drinking in Past 12 Months Number*	
Illicit Drugs or Prescriptions in Past 12 Months Number*		Mental Health Concern in Past 12 Months*	☐ Yes ☐ No
Tuberculosis Risk *Required when Provider Contract Type requires screening for TB*	☐ Positive ☐ Negative ☐ Refused	Suicide Risk Screening *Required when Provider Contract Type requires screening for Suicide*	☐ Suicide Risk Indicated ☐ Suicide Risk Not Indicated ☐ Refused

Client Demographic

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Military Status*	☐ Veteran ☐ Not a Veteran ☐ Refused	Marital Status*	☐ Never Married ☐ Now Married ☐ Widowed ☐ Divorced

	☐ Separated ☐ Refused
Residence County*	

Financial and Household

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Primary Income Source*	☐ Wages/Salary ☐ Public assistance ☐ Retirement/ Pension ☐ Disability ☐ None ☐ Other ☐ Refused	Health Insurance*	☐ Private insurance ☐ Blue Cross/Blue Shield ☐ Medicare ☐ Medicaid ☐ Health Maintenance Organization (HMO) ☐ Other (e.g. TRICARE) ☐ None ☐ Refused
Living Arrangement* *See vocabulary key for all Living Arrangements.*		Monthly Household Income Known*	☐ Yes ☐ No ☐ Refused
Monthly Household Income Amount *Required if Known is yes*		Others Helped Financially in Past 6 Months*	☐ Yes ☐ No
Ever Declared Bankruptcy* *Required if Program Area is Gambling*	☐ Yes ☐ No	Debt Amount*	
Money Lost Gambling in Past 30 Days* *Required if Program Area is Gambling*		Children 17 and Under Known*	☐ Yes ☐ No ☐ Refused
Children 17 and Under Count*		Custody of Children 17 and Under Count *Required if Known is Yes*	

Education and Employment

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Education Grade Level* *See vocabulary key for all Grade Levels*	Employment Status* *See vocabulary key for all Employment Statuses*

Legal

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Arrests in Past 30 Days Known*	☐ Yes ☐ No ☐ Refused	# Arrests in Past 30 Days *Required if Known is Yes*

Arrests Related to Gambling in Past 30 Days *Required if Known is Yes and Program Area is Gambling*	☐ Yes ☐ No ☐ Refused	Arrests Related to Substance Use in Past 30 Days *Required if Known is Yes and Program Area is Substance Use*	☐ Yes ☐ No ☐ Refused

Overdose

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Lifetime Overdoses Known*	☐ Yes ☐ No ☐ Refused	# Lifetime Overdoses *Required if Known is Yes*	
# Lifetime Treated Overdoses *Required if # Lifetime Overdoses >0*		Past 30 Days Overdose*	☐ Yes ☐ No ☐ Refused

Suicide Risk

Suicide Risk should be provided if Pre-Screening results were positive for Suicide Risk

Suicide Risk Assessment Completed*	☐ Yes ☐ No ☐ Refused	Suicide Risk Assessment Result*	☐ Imminent Risk ☐ Non-Imminent Risk
Suicide Safety Plan Developed or Reviewed*	☐ Yes, plan was developed ☐ Yes, existing plan was reviewed ☐ No ☐ Refused	Transfer to Hospital Due to Suicide Risk*	☐ Yes ☐ No ☐ Refused

Screening Results

Positive Pre-Screenings must have a Screening Result.

Program Area Code*	☐ Substance Use Disorder Treatment ☐ Gambling Treatment	Recommended ASAM Level of Care* *See vocabulary key for all Recommended ASAM Levels of Care*
Intention to Follow Recommendation*	☐ Yes ☐ No	

Program Area Code*	☐ Substance Use Disorder Treatment ☐ Gambling Treatment	Recommended ASAM Level of Care* *See vocabulary key for all Recommended ASAM Levels of Care*
Intention to Follow Recommendation*	☐ Yes ☐ No	

Overdose – Overdose Events in Past 30 Days

Required if "Past 30 Days Overdose" is Yes

Substance Type* *See vocabulary key for all Substance Types*		
Was Treated*	☐ Yes ☐ No ☐ Refused	Treatment Location Type *Required if Was Treated is Yes* *See vocabulary key for all Treatment Locations*

Substance Type *See vocabulary key for all Substance Types*		
Was Treated	☐ Yes ☐ No ☐ Refused	Treatment Location Type *Required if Was Treated is Yes* *See vocabulary key for all Treatment Locations*

Substance Type *See vocabulary key for all Substance Types*		
Was Treated	☐ Yes ☐ No ☐ Refused	Treatment Location Type *Required if Was Treated is Yes* *See vocabulary key for all Treatment Locations*

Recovery Groups

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Recovery Group Type*	☐ Substance use self-help group *Required if Program Area is Substance Use* ☐ Gambling self-help group *Required if Program Area is Gambling* ☐ Other	Days Attended in Past 30 Days*

Recovery Group Type	☐ Substance use self-help group *Required if Program Area is Substance Use* ☐ Gambling self-help group *Required if Program Area is Gambling* ☐ Other	Days Attended in Past 30 Days

Recovery Group Type	☐ Substance use self-help group *Required if Program Area is Substance Use* ☐ Gambling self-help group	Days Attended in Past 30 Days

Required if Program Area is Gambling

☐ Other

Substances Used

If the Provider Treatment Episode indicates Yes for the Intravenous Substance Use In Past 30 Days Codefield, then there should be at least one Substance Used with a Route of Administration Code of Injection where the Performance Outcome Measure Date is greater than or equal to the Open Date and less than 30 days after the Provider Treatment Episode Open Date.

Report all substances used at the time of the Performance Outcome Measure. If using only one substance, report the substance used under "Substance Used #1).

Substance Used #1

Required if Care Status Program Area is Substance Use

Substance Type* *See vocabulary key for all Substance Types*			
Detailed Type* *See vocabulary key for all Detailed Substance Types*			Substance Rank Number* 1
Route of Administration*	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other ☐ Refused	Past 30 Days Frequency*	☐ None in the past month ☐ 1-3 days in the past month ☐ 1-2 days in the past week ☐ 3-6 days in the past week ☐ Daily ☐ Refused
Age of First Use*			

Additional Substance Used (If Applicable)

Substance Type *See vocabulary key for all Substance Types*			
Detailed Type *See vocabulary key for all Detailed Substance Types*			Substance Rank Number 2
Route of Administration	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other ☐ Refused	Past 30 Days Frequency	☐ None in the past month ☐ 1-3 days in the past month ☐ 1-2 days in the past week ☐ 3-6 days in the past week ☐ Daily ☐ Refused
Age of First Use Number			

Additional Substance Used (If Applicable)

Substance Type *See vocabulary key for all Substance Types*			
Detailed Type *See vocabulary key for all Detailed Substance Types*			Substance Rank Number 3
Route of Administration	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection ☐ Other ☐ Refused	Past 30 Days Frequency	☐ None in the past month ☐ 1-3 days in the past month ☐ 1-2 days in the past week ☐ 3-6 days in the past week ☐ Daily ☐ Refused
Age of First Use			

Mental Health Symptoms

Mental Health Symptoms should be provided if Pre-Screening results were positive for Mental Health Concern

Each table should apply to only one symptom. For any additional symptoms, please complete an additional table.

Mental Health Symptom*	☐ Experienced serious depression ☐ Anxiety/Tension ☐ Hallucinations ☐ Attempted suicide ☐ Trouble controlling violent behavior ☐ Trouble understanding/ concentrating or remembering ☐ Been prescribed medication for psychological/emotional problems ☐ Refused		Symptom in Past 30 Days Number*
Bothered by Symptom in Past 30 Days*	☐ Yes ☐ No ☐ Refused	Receiving Help with Symptom*	☐ Yes ☐ No ☐ Refused
Interested in Receiving Help with Symptom *Required if Receiving Help is No*		☐ Yes ☐ No ☐ Refused	

Mental Health Symptom*	☐ Experienced serious depression ☐ Anxiety/Tension ☐ Hallucinations ☐ Attempted suicide ☐ Trouble controlling violent behavior ☐ Trouble understanding/ concentrating or remembering ☐ Been prescribed medication for psychological/emotional problems ☐ Refused		Symptom in Past 30 Days Number*
Bothered by Symptom in Past 30 Days*	☐ Yes ☐ No ☐ Refused	Receiving Help with Symptom*	☐ Yes ☐ No ☐ Refused
Interested in Receiving Help with Symptom *Required if Receiving Help is No*		☐ Yes ☐ No ☐ Refused	

Mental Health Symptom*	☐ Experienced serious depression ☐ Anxiety/Tension ☐ Hallucinations ☐ Attempted suicide ☐ Trouble controlling violent behavior ☐ Trouble understanding/ concentrating or remembering ☐ Been prescribed medication for psychological/emotional problems ☐ Refused		Symptom in Past 30 Days Number*
Bothered by Symptom in Past 30 Days*	☐ Yes ☐ No ☐ Refused	Receiving Help with Symptom*	☐ Yes ☐ No ☐ Refused
Interested in Receiving Help with Symptom *Required if Receiving Help is No*		☐ Yes ☐ No ☐ Refused	

Medication Assisted Treatments

Required if Care Status Program Area is Substance Use

Medication Type*	☐ Methadone ☐ Naltrexone ☐ Disulfiram ☐ Other	☐ Buprenorphine ☐ Acamprosate ☐ LAAM ☐ None

Diagnoses

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

Primary

Code Set Identifier*	☐ ICD-10	
Rank Number*	1	Diagnosis Code*

Secondary

Code Set Identifier	☐ ICD-10	
Rank Number	2	Diagnosis Code

Tertiary

Code Set Identifier	☐ ICD-10	
Rank Number	3	Diagnosis Code

Stages of Change

Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.
A Stage of Change is required for each positive Pre-Screening Program.

Program Area	☐ Substance Use Disorder Treatment	☐ Gambling Treatment
Stage	☐ I have no intentions of changing my behaviors ☐ I am considering reducing or stopping my behaviors within the next 6 months ☐ I reduced/quit my behaviors over 6 months and have been able to maintain these changes	☐ I plan to quit or reduce my behaviors in the next month ☐ I have already begun to reduce/quit my behaviors in the past 6 months ☐ Refused

Quality of Life Measures

Required for Pre-Admission Care Status. Required if POM is used for one or more Care Statuses with an Admission, Transfer, or Discharge type.

	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
How would you rate your quality of life?*					
How satisfied are you with your health?*					
How satisfied are you with your ability to perform your daily living activities?*					
How satisfied are you with yourself?*					
How satisfied are you with your personal relationships?*					
How satisfied are you with the conditions of your living place?*					
How satisfied are you with your mental health?*					

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Do you have enough energy for everyday life?*					
Do you have enough money to meet your needs?*					

Gambling Wager Activity Type

Required if Care Status Program Area is Gambling.

Primary

Profile

Activity Type* *See vocabulary key for all Gambling Wager Activity Types.* *Use "None" only if Concerned Individual is Yes.*	Activity Type Rank Number* 1
First Wager Age*	Past 30 Days Frequency* ☐ None in the past month ☐ 1-2 days in the past week ☐ Daily ☐ 1-3 days in the past month ☐ 3-6 days in the past week ☐ Refused

Gambling Wager Activity Locations

Gambling Wager Location*	☐ Casino ☐ Home or Friend's Home ☐ Racetrack ☐ Other Sporting Event ☐ Smart Phone	☐ Convenience Store ☐ Internet/Online (Computer) ☐ School ☐ Work ☐ Other

Secondary Profile

Activity Type* *See vocabulary key for all Gambling Wager Activity Types.* *Use "None" only if Concerned Individual is Yes.*		Activity Type Rank Number* 2
First Wager Age*	Past 30 Days Frequency*	☐ None in the past month ☐ 1-2 days in the past week ☐ Daily ☐ 1-3 days in the past month ☐ 3-6 days in the past week ☐ Refused

Gambling Wager Activity Locations

Gambling Wager Location*	☐ Casino ☐ Home or Friend's Home ☐ Racetrack ☐ Other Sporting Event ☐ Smart Phone	☐ Convenience Store ☐ Internet/Online (Computer) ☐ School ☐ Work ☐ Other

Tuberculosis Risk Responses (during treatment, more than one response may apply)

Tuberculosis Risk Responses should be provided if Pre-Screening results were positive for Tuberculosis Risk

Tuberculosis Risk Response Type	☐ Tuberculosis Test ☐ Tuberculosis Counseling ☐ Tuberculosis Medical Evaluation/ Treatment	Tuberculosis Risk Response Location	☐ Onsite ☐ Offsite ☐ Pending ☐ Refused

Tuberculosis Risk Response Type	☐ Tuberculosis Test ☐ Tuberculosis Counseling ☐ Tuberculosis Medical Evaluation/ Treatment	Tuberculosis Risk Response Location	☐ Onsite ☐ Offsite ☐ Pending ☐ Refused

Tuberculosis Risk Response Type	☐ Tuberculosis Test ☐ Tuberculosis Counseling ☐ Tuberculosis Medical Evaluation/ Treatment	Tuberculosis Risk Response Location	☐ Onsite ☐ Offsite ☐ Pending ☐ Refused